

Tape # 16  
Dr. M. E. DeBakey  
with Don Schanche

Houston, Texas

8/72 (final hour)

DR. DeBAKEY: The Fellow we had in cardiovascular surgery  
during '66-'67 is Marius Barnard, the brother of..

SCHANCHE: Was that Christian Barnard's brother?

DR. DeBAKEY: Yes.

SCHANCHE: Aah.

DR. DeBAKEY: He served as a Fellow here.

SCHANCHE: Well, Christian Barnard was trained in Minnesota.

DR. DeBAKEY: That's right.

SCHANCHE: How was Marius Barnard as a surgeon?

DR. DeBAKEY: Well...

SCHANCHE: Like the other South Africans?

DR. DeBAKEY: Yeah, I regarded.. We all regarded him as average.  
Not outstanding, not above average. We point out  
construction is nearing completion on the Fondren-  
Brown.

SCHANKE: You must be on page 17.

DR. DeBAKEY: Yeah.

SCHANKE: I made a note of that. Was this the last report you did? You didn't do any more after you became president?

DR. DeBAKEY: Yeah.

SCHANKE: Oh, you did?

DR. DeBAKEY: Yeah. This is not the last report. There's one in press right now.

SCHANKE: But you didn't do a '68-'69?

DR. DeBAKEY: Well, it's in press. I don't know why, but it is.

SCHANKE: Here it is 1972 and...

DR. DeBAKEY: I know. All these were delayed getting out.

SCHANKE: Were they?

DR. DeBAKEY: Yeah. Oh, yeah.

You see the Engineering and Science Award from the Federation of Engineering and Scientific Societies. The Golden Plate Award.

SCHANKE: What was the basis of that ? Instrument development?

DR. DeBAKEY: Yeah.

SCHANKE: Something specific like the heart?

DR. DeBAKEY: Well, primarily, the artificial heart.

The Golden Plate Award from the American Academy of Achievement. The Dixon Medal. This is in Belfast, Ireland. The Horatio Alger Award. The Great Collar with Golden Medal from the--Dag Hammarskjöld gave that--the international Dag Hammarskjöld prize. That's in Milan, Italy. That's a beautiful thing.

SCHANKE: The kind you would wear to a diplomatic reception?

DR. DeBAKEY: That's right.

And I was on the "Today" show December 12, 1966, taped a talk on "Heart Surgery" and the NBC-TV "Research Project" Series--Greater New York.

The American Medical Writers' Association Honor Award. The Eugene H. Drake Memorial Award from the Maine Heart Association. The Christopher Columbus Award from the Columbus Day U.S.A. Association. Honorary membership in Omicron

DR. DeBAKEY: Delta Kappa Society. Honorary Fellowship, Royal College of Surgeons in Ireland. Visiting Professor at Cincinnati General Hospital. Scientific presentations and publications. The various divisions.

SCHANKE: Yeah, I think you had gone to a format of listing each division separately.

DR. DeBAKEY: Yeah, separately. That's right. Yeah, that's the last one that's here.

SCHANKE: That is the last one.  
Can I keep those? Do you have other copies of them?

DR. DeBAKEY: Uh..

SCHANKE: Or could you send some?

DR. DeBAKEY: Let me send you , yeah, I think I'd better send you copies of them.

SCHANKE: Alright, fine.

DR. DeBAKEY: Let me make a note of that. What did I do with the other things?

SCHANKE: Okay, you want to go back now to the first left-ventricular pump.

DR. DeBAKEY: The left ventricular bypass pump?

SCHANKE: Yeah, with the DeRuther case.

DR. DeBAKEY: Well,...

SCHANKE: Which you came in for a very hard public situation.

DR. DeBAKEY: Well, you have to go back to.. I'd have to go back to a meeting of the New York Heart Association. They were celebrating their golden anniversary. The New York Heart Association is the oldest heart association. It's older than the American Heart Association. And they had invited Dr. Paul White and me to be their featured speakers that evening. And I gave a kind of review of the advances in surgical therapy and he gave a review of the advances in medical therapy. And I wound up my talk with the work on the artificial heart--the experimental work. Then I said that --I showed slides of the development of the left ventricular bypass pump and told about the experimental work on it and I said that I thought that we would soon have this in clinical application. Well,

DR. DeBAKEY: that created a great deal of publicity. You know, the next day it was in all the head-lines. And then we were called constantly by news media. When were we going to do it? And so several of them simply came down and saw--made, sort of made indepth interviews in the laboratory and reviewed the experimental work and so on. And the next thing we knew, they had a television truck out here.

SCHANKE: Standing by?

DR. DeBAKEY: Standing by. That's right. Just standing by and waiting.

SCHANKE: Was this one of the networks?

DR. DeBAKEY: One of the networks. And the reporters were all around--looking around. And it really got to be kind of hairy around here. So, I decided that the best thing for me to do-- We didn't have a public relations office like we have over at Baylor now. So I decided to turn this over to the administration of Methodist Hospital. I said, "Look, you know, you've got to

DR. DeBAKEY: handle this. I can't handle this." So, we were going--trying to go ahead with our business. Next thing I knew, we had a patient--this man DeRuther, who had a very, very severe valvular heart disease and was really in sort of the last stage of failure. The medical people couldn't do a thing with him to get him out of failure. And he was really sort of a candidate for a heart transplant. Well, we reviewed it very carefully and finally we decided that the only thing--the only chance he had was an operation on his valve, but because he had such severe heart failure, we didn't know whether we could get him off the pump, you see. In other words, whether after we completed it his heart would be able to take over. Well, as it turned out, it wasn't able to. Well, this being our first use of it, we were all prepared and ready to do it. We had gone through this with the patient and the family--the wife. Incidentally, his wife still writes me from time to time. She was really a nice lady. And I explained it all to them.

DR. DeBAKEY: You know, what we were doing. And what we might do with this pump, so we had their complete approval to use it. We went through the fact that we had done this experimentally and knew what we should do with it. The safety use for that period of time. Now, when we did it, you see, we took some movies. We have our own photographer taking movies of it. They learned of our doing this because they were around here. There was no way, you know, if an interprising reporter wants to get a story, then there's hardly any way you can prevent it. You just can't get.. I mean this is the experience we've had here, any way. They are so persistent and so aggressive and so determined, you can't isolate the hospital. And everybody who's had any experience with them has found that out. Some of the people who were sort of critical of us when the heart transplant work came in. They found out differently. You know, they found out you couldn't. You know, they said, "You can do it." But you can't.



DR. DeBAKEY: There is no way in a public hospital. Now they..  
The Life people, the various television programs,  
I mean television news media and so on had all their  
crews here. Now they were not allowed in the  
operating room. I said, "No, they can not be allowed  
in the operating room." That I could stop. So we  
wouldn't allow a single one of them in the operating  
room. And they didn't get in the operating room.  
But they persisted in getting some photographs. And  
the administration allowed them to use certain types  
of photographs showing..

SCHANKE: These were a film..

DR. DeBAKEY: No, yeah wait a minute. Showing the use through the  
bypass, you see. And before I knew what had happened,  
because I had turned over the responsibility of dealing  
with them to them--one of the assistant administrators  
took these photographs and allowed them to select  
some photographs from them. I didn't know that this  
had happened, you see. When I found out about it

DR. DeBAKEY: it was too late. They had them. What is even more..

SCHANKE: This was film from your own photography department?

DR. DeBAKEY: From our own photography department. That's right.

And this is how Life got them. Now, the movies that they got hold of too came the same way. This all happened before I had even seen the photographs. Now I was..I was completely occupied with this patient. After the operation, I went with the patient to this special intensive care unit which we had developed. Not the regular. We set up a special unit for this purpose on a different floor. And I stayed there and lived there with this patient the whole time.

SCHANKE: Did you have a cot there?

DR. DeBAKEY: Yeah, I had a cot there and everything. So I hardly was outside. And had little or no opportunity to see what the hell was going on. Then, you know, after this happened, I saw in the papers and so on what was taking place. There wasn't any way I...

SCHANKE: It was a major story all over the country.

DR. DeBAKEY:

That's right. You know, and there wasn't any way that I could have prevented what they did. You know, they would have gotten something anyway, no matter what. And the assistant administrator who isn't here now and I don't mean this as critical of him because he just couldn't deal with it-- You know, he was unable to deal with it. Mr. Bowen was a little upset about it too, because he had had the responsibility to deal with it and he didn't do it just the way he wanted it. Well, of course, we were severely criticized about it. You know, all this publicity. Now, the unfortunate thing too, it was never publicized quite right, you see. It never was intended to be an artificial heart. It was an assist device. But, using the term artificial heart is far more catchy from a public standpoint, you see. And it never was intended to replace the heart at all. It was intended to assist the heart temporarily only. Well, of course, it almost--it just got out of hand. The publicity. The news.. They had

DR. DeBAKEY: a good story and they weren't going to let it go.  
And they persisted in the story and carried details  
everyday. They had bulletins and everything else.  
And, of course, the man died about--I've forgotten..

SCHANKE: About five days.

DR. DeBAKEY: Yeah, something like that. He died from the compli-  
cations of his bad heart, you see. We had a second  
case that also died--lived a little longer, but died.  
And then the third case was quite successful. And  
that lady is still living.

SCHANKE: She was a fairly young Mexican girl.

DR. DeBAKEY: Yes. She was .. But she was actually in some  
respects sicker than the man.

SCHANKE: Was she?

DR. DeBAKEY: Yeah. She was very, very sick.

SCHANKE: What was her...?

DR. DeBAKEY: Double--both valves--the mitral and the aortic valves.  
I replaced them both.

SCHANKE: How long was she..?

DR. DeBAKEY: She was on the pump for thirteen days.

SCHANKE: Thirteen days.

DR. DeBAKEY: Yeah. Yeah. And she was really a remarkable case. We.. You know, we published all of this. It's in one of the publications which you were seeing. She was here about two or three months ago for a check-up. She's done extremely well. She's been abroad. She's a hair dresser. And she works regularly as a hair dresser. Now six years and she's doing extremely well.

Another case was one from Yugoslavia which also is quite successful. A valve replacement.

You see, the reason we use it the way we use it is because you have to operate on a patient to use this type of left ventricular bypass pump. To attach it. Now, since we have to operate on a patient for valvular heart disease, this is what we did. We used it. The operation already was there. We had all the exposure and so on. And it was a beautiful demonstration of how

DR. DeBAKEY: a mechanical pump can assist the heart in increasing the total outflow of blood from the heart. Increasing the total cardiac output. And we had beautiful physiologic data. We published it all. The data is clear. And it has proved to be quite a useful instrument. Now, we're coming back to it with coronary cases. And we're going to apply it--since we are operating on the coronaries--we have the exposure--we can use it. That's the only disadvantage.

SCHANCHE: You haven't used it for quite some time.

DR. DeBAKEY: No, we haven't used it for some time. And the reason we haven't used it for some time is because we haven't had the money in the grant for this purpose. Now it costs us on the average of ten to fifteen thousand dollars per case to use it. And we just haven't had that money.

SCHANCHE: How many did you do? Five?

DR. DeBAKEY: No, we did about.. I think we did six.  
We've gotten some additional funds recently and we're

DR. DeBAKEY:

going to.. And we're now putting together a better pump in many ways--a more sophisticated pump. And we'll have it ready almost any day now. We could have used it today on a patient. We've had several occasions when we wanted to use it badly on coronaries. And I think we'll... It'll be quite useful.

You know, this publicity business is so easily misinterpreted and so easily abused. And that's why, generally speaking, the medical profession is very critical of doctors who, in a sense, get a lot of publicity. Because, it is easy to abuse it. And if one isn't extremely careful, it can create the impression that you are seeking publicity. So that I was subject to that kind of criticism because of the widespread publicity. Now, I can say sincerely that I never tried to seek publicity. For one thing, it doesn't really appeal to me to just--to seek it, so to speak. On the other hand, wherever I have been able to publicize, so to speak, a program, let's say of

DR. DeBAKEY: medical service or medical care or medical research which allows for education of the public, then I'm willing to do that. I've always wanted to use any method to provide public education because I think it's essential that the public understand and support medical research and medical education.

SCHANKE: Is that your principal criterion for agreeing to or disagreeing to that kind of public exposure?

DR. DeBAKEY: Yes, I think this ought to be, in a sense, your main criterion. And secondly I think it ought to be done as honestly, as factually as you can do it. To be sure--utilizing language that's easily understood. At the same time, be quite factual. And it is desirable, in fact, one of the recommendations we made in, for example, in the Heart Disease, Cancer, and Stroke Commission was a public education program sponsored by the federal government. That is supported, not necessarily done by them, but supported by them.



DR. DeBAKEY:

To illustrate a point, hypertension--high blood pressure--we know enough about high blood pressure to know that we can in the great majority of cases control it well. Satisfactorily. We know that it is dangerous to allow high blood pressure to go uncontrolled. That it will shorten the life of the individual. It will lead to many complications and that it at least can be avoided. Well, this has been well-demonstrated. In fact, one of the men who did demonstrate this well received the Lasker Award last year for the studies that he did to show this--demonstrate it. We've known this though for years. But you cannot, no matter what you do as a physician--you can not get the patients to come in to be examined to determine whether they have high blood pressure unless the patients themselves--the people--recognize its importance. You see. And literally thousands of people go unrecognized because they don't take the initiative to do anything about it until it's too late.

SCHANKE: And it doesn't help to have doctors refusing to go on television and talk about it.

DR. DeBAKEY: No. No. You see. You've got to have someone to explain it to the public. So it's important that you create some kind of public educational program. This is just one example of many others. Of what you can do to help control these diseases. So the public needs to cooperate in the control of diseases.

SCHANKE: Do you think local medical societies could be doing a lot more than they are in this regard?

DR. DeBAKEY: Oh, I think so. Very definitely. I think the American Medical Association could do more. I think that more.. You see, it takes more money to do this. Well, I think they ought.. in other words, I think some of the monies ought to be spent on education. Now the American Heart Association has a certain budget for public education, but it's very small. It's completely inadequate. And I think that the federal government should expend more money in this area. You see, they..the

DR. DeBAKEY: fed...as taxpayers, we put certain monies in the federal fund for the people. Now part of those monies should go into helping educate the people to improve their health. The prevention of disease and the control of disease requires in many instances the cooperation of the people with the physicians. This means that the people can't cooperate if they don't know what to do. But if they're educated to what to do, they can. So there ought to be a very important strong public education program which actually begins in the grammar schools. And is continuous.

SCHANKE: They spend some money in this area now.

DR. DeBAKEY: But, very, very little. It's very inadequate.

SCHANKE: I mean some cartoon, television things for Captain Kangaroo and this sort of thing. The H. E. W. pays for it.

DR. DeBAKEY: Yes, that's right. But it's a very small amount. It's a very small amount. There should be spots on the television program everyday. There should be

DR. DeBAKEY: programs of some kind that's nationally recognized. They should be done professionally. Should be done so they're amusing. They're interesting. You know, people are not going to look at something--they'll turn it off and look at something else. You've got to attract their attention. This means that you've got to have talented people doing it. This costs money. This costs money. I mean look at what Madison Street does--Madison Avenue people do. Christ, they'll sell you everything. Things you don't need.

SCHANKE: Most of what you don't need.

DR. DeBAKEY: Yeah, most of what they sell you, you don't really need. But they sell it. Well, hell, you need good health. They could sell that. But you're not going to get those people to work on this if they aren't paid for it. They're going to work for something they're paid for. In other words, you've got to compete for talent. And that's why you've got to spend the money. That's what I say about medical research. If you

DR. DeBAKEY: compete with NASA, you know, in going to the moon, you've got to have a budget like NASA has. They're going to spend five or six billion dollars a year. They're going to get the talent. You're not going to get it. It's just that simple really. And that's why I'm for spending more money for health. When you think in terms of our total budget-- I'm talking about federal budget now--say two hundred billion dollars a year or in excess of that. The amount that we spend for our health out of that two hundred billion dollars a year constitutes a very, very small percentage. Now, to me this is a matter of priorities. This is a matter of priorities. Well, I just don't believe that my health and your health has such a low priority. And you don't either when you get sick.

SCHANKE: No, it's higher than getting to the moon.

DR. DeBAKEY: That's right. It becomes a very important priority. It's right at the top of the list. But, prevention is far more important, far more economical, far more.

DR. DeBAKEY: The amount of money it took to solve the problem of poliomyelitis was much less than the amount of money we spent in any one year for taking care of patients with poliomyelitis. Think of that. You see. It's just that simple.

SCHANKE: That would be even more true with heart disease, wouldn't it?

DR. DeBAKEY: Oh, of course. Of course, it is. Because..

SCHANKE: It's a much more complex problem.

DR. DeBAKEY: It's a much more complex problem and it's a much greater problem--the magnitude of it. So great. When you think--realize there's over a million deaths a year. There are only, I would say average of something like twenty to twenty-five million people in our population that suffer from heart disease. It's been estimated that it would cost the nation, in terms of its total cost, possibly on the order of something like , well, all told, for all of it including loss of work, a loss of revenue, income and so on--perhaps twenty-four billion dollars.

SCHANCHE: Per year?

DR. DeBAKEY: Yeah. There you are. You see.

SCHANCHE: For twenty-four billion dollars could you practically guarantee a solution?

DR. DeBAKEY: No, you can't guarantee solution for any amount of money. But the one thing you can guarantee is that there won't be any solution without the money. That's the one thing you can be sure of.

SCHANCHE: How does that figure break down, Mike? I've seen it a lot--the billion heart disease. You're covering all of the..

DR. DeBAKEY: All of heart disease.

SCHANCHE: Vascular..

DR. DeBAKEY: Cardiovascular diseases. Coronary disease alone accounts for more than a half of it.

SCHANCHE: Does it?

DR. DeBAKEY: Yeah. That's right.

SCHANCHE: What are the comparable figures for cancer? Do you know?

DR. DeBAKEY: Yeah. About three-hundred and thirty thousand.  
About one-third.

SCHANKE: The same would be true of the economic loss also.

DR. DeBAKEY: Yeah. We have all those figures in the report of  
the President's Commission on Heart Disease,  
Cancer and Stroke. Yeah.

SCHANKE: But they're now eight years out of date.

DR. DeBAKEY: Well, except really you could simply say you could  
almost, you know, ..

SCHANKE: Extrapolate.

DR. DeBAKEY: Extrapolate. That's right.

SCHANKE: Back to the ventricular bypass pump rather, in..  
because one critical element arose after the Cooley  
episode that you had done the same thing with that  
that he did with the artificial heart...

DR. DeBAKEY: Well, no, you see. There are several big differences.

SCHANKE: I know that.

DR. DeBAKEY: One is we didn't steal it. Secondly, is we had good  
documentation.

SCHANKE: You had long testing.



DR. DeBAKEY: Long testing on animals and good documentation. And had presented it at many meetings--scientific meetings, you know, the experimental work. Published it. Thirdly, we had approval from our committee, you see, research committee--human research committee. More than that, we had approval for every case. We presented each case to the research committee.

SCHANKE: You do have to do that?

DR. DeBAKEY: No, you don't. But we did. Because I wanted a committee of my own, that is a committee of cardiologists and internists to approve it. In other words, I didn't want to do it..or have this whole responsibility for selecting the cases. You see. So, .. And it was no secret. We didn't try to hide it.

SCHANKE: Yeah. You also did..you had a considerably better animal research to fall back on.

DR. DeBAKEY: Oh, well , we had.. No, well, you see our animal research work clearly demonstrated that.. In fact,

DR. DeBAKEY: we carried some animals for three months on it. We knew exactly what the animal..you see, the pump worked on animals for as long as three months, but in most instances we found that after six weeks the pump would tend to thicken--the wall would thicken too much. But in some instances, it was possible to carry it for three months. But the great majority of instances.. You see, our purpose in the clinical-- We knew that if a patient wouldn't come back within a week or so, his heart's not going to come back.

SCHANKE: It was very unlikely you'd ever need it.

DR. DeBAKEY: That's right. That's right. And that was our premise. And that proved to be true..

SCHANKE: In the tests on the patients, particularly the one who had it for thirteen days, was there much damage to the body? During that time?

DR. DeBAKEY: That was the interesting thing. Less than there was in the animal.

SCHANKE: Really?

DR. DeBAKEY: Yeah. Yeah. And the reason for that was that they developed.. The human reaction is less well, it's more tolerable. Man is in some respects more tolerant than animals.

SCHANCHE: Takes more..

DR. DeBAKEY: Takes..that's right. He can take more of a beating. Oh, we had beautiful data. There wasn't any complications from its use.

SCHANCHE: Then that puts down that odious comparison in a nutshell.

DR. DeBAKEY: Yeah. Well, you see, the animal experience puts it down right away. We had done over three hundred animals.

SCHANCHE: With good results.

DR. DeBAKEY: Oh, excellent results. Yeah. We had good data on the animals too. Sure.

SCHANCHE: How long.. Work on that actually began prior to 1964, didn't it? Before you got the grant?

DR. DeBAKEY: Oh, yes. Yes, we started before. That's right.  
Oh, yes. As a matter of fact, we started about sixty..

DR. DeBAKEY: I would say '61 or '62--something like that.  
That's when we started to work on it.

SCHANKE: Well, I think we've probably reached about the  
end of what we can do on the tape recorder, Mike,  
to your relief. I can see.

DR. DeBAKEY: No, no. I've enjoyed it. I hope you haven't felt  
that...

(BRIEF PAUSE)

DR. DeBAKEY: The total experience of.. in medicine and while  
my experience before the war was very narrow,  
it was sort of still goal-oriented. I wanted to be  
a surgeon and I wanted to work in the circulation  
area in the vascular area. And, but I had no  
broader vision, so to speak. The war experience  
really opened up my whole sort of vista. I mean  
my horizons just widened tremendously from the  
war experience. And I learned a great deal about  
how things got done. How you had to overcome  
frustration, so to speak. How you handled those  
frustrations. How you pinpointed the approach to

DR. DeBAKEY: an objective using people who could help you do that. Getting to the right person, I learned during the war, was the way to get things done, even if you had to go over heads, you did this by not letting them know you went over their heads. Of course, sooner or later, they'd find out, but by that time it was done

SCHANKE: ~~not~~ Systematic Machiavellian..

DR. DeBAKEY: Yeah, you see. It's sort of..

SCHANKE: It looks to me like that experience broadened you politically in that you learned how to get things done-- philosophically in that you began to sense what needed to be done.

DR. DeBAKEY: Well, yes. You see, I wasn't even aware what needed to be done before. And you see, here I grew in a sense from the medical standpoint in a charity hospital. I was dealing with charity patients. This is the low economic group--both whites and Negroes, predominately Negroes, but also poor white people. And it never

DR. DeBAKEY:

occurred to me, you know, that their lot should be better. I was concerned with their health. I was trying to help them get well and we treated them not as charity patients, you know. That's the very nice thing about Charity Hospital in New Orleans. It has that..of course it may be because of the fact that it has the heritage of being a charity hospital. The reason it's called Charity Hospital, you know, is because the Sisters of Charity run it. It is a charity hospital, but it's called charity because of that. And that may be one reason that .. because of the Catholic influence that gave it this kind of compassion to the people. So I learned compassion there, although I had learned compassion from my family, from my parents.

SCHANKE:

That's with people as patients. You lost sight of them when they went out the door of the hospital.

DR. DeBAKEY:

That's right. No. That's right. The reason that I've changed my views about the care of patients

DR. DeBAKEY:

and the need for a sort of national program is because I have learned that there is no other way to get equal care for people. And I've also learned in a sense that illness creates equality in every respect. And therefore you should deal with it realistically on an equal basis. But I, of course, intellectually, I must say that I justify this not just from compassion, although I must say I've thought it out compassionately. I justify it on a.. on the basis that it is in the best interest of a society to do this. In other words, as a member of society it is a part of my responsibility to keep you well, because if you aren't well, then it becomes my burden economically to take care of you whether I like it or not. Well, it's much better for me to keep you well and in a sense economically well and not have me take care of you. So, from a society standpoint, it is important that the health of the people, all the people be cared for on an equal basis.

SCHANCHE: More than an economic burden also, it involves your security of everything else.

DR. DeBAKEY: Of course it does. Well, I'm using only one aspect. One facet of it--the economic facet of it. It also, as you say, it effects the mental health of the people too. Their outlook. The joy of living. Everything else. Yes, you can't. Yes, productivity, creativity, the pleasure of living. We've got to live together. There's no way for each one of us to be a hermit. So it is our responsibility. So intellectually, I'm convinced that health is something different in a society--from a society's standpoint--than automobiles, even though automobiles are essential to transportation. In other words, it's different from transportation. It's different from clothing. It's different from many other endeavors in society. It's different from art. Different from literature. It is a part of living--of being alive. You see. Therefore, it becomes as essential and as equal to everyone as the air you breath or the water you drink. And so



DR. DeBAKEY: I set aside health as something that's kind of sacred. And therefore should be made available to every person in the same fashion that the air is made available to them. You know, it's God-given. It is an absolute right that you have once you're born. Absolutely undeniable right and therefore it becomes just as much my responsibility as yours to see to it that we each get health. That it's available to us. Now that's a different thing--though, that's a philosophical or let's say intellectual philosophical approach to health. That is not saying how it's to be done. All I'm saying is that once we start with that premise, then we can...

SCHANKE: You have established your priority there.

DR. DeBAKEY: That's right. Then we can decide how best to see that it's equally done. How best do we achieve it. You see. Well, I don't.. I'm not taking any strong position on how you best do it. I'm merely saying that if we agree to that then we should be able to work out a way that will provide it. That's all. There

DR. DeBAKEY: are many different ways you do things in society that gives people equal access to the fruits of society. Taxation is one of them. Now you might say, "Well, taxation is not equally done." Well, but that's a different thing.

SCHANKE: It ought to be.

DR. DeBAKEY: It ought to be, but it isn't. Alright, let's say it isn't. Defense. We share to provide all of us defense. We share to provide the society with police protection. We share to provide the society with those kinds of activities. And how do we do that? We do that through taxation. Now all I say is that you can develop ways and means of taxing the individual. You may want to tax his pay check. You may want to tax his employer and you may want to tax him on a general basis. The development of how you support it becomes still another matter for experts to work out. Then, the provision of it once you have the funds for it--the provision of it becomes still another matter. The theory of it. And again

DR. DeBAKEY: I come back to the premise.

SCHANKE: But you have pretty clear ideas in this area.

DR. DeBAKEY: Well, I have some ideas as to how I think it might best be done, but I'm willing to say that there might be better ideas. I'm not saying.. The one thing that I've sort of come away from, at least in our society, is that it be provided by the government. I'm not sure that.. in fact I'm reasonably certain in my mind that it shouldn't be provided in the way we provide medical service to the Army or the Veterans Administration. But it can be done in a free society and we can have prosody and pluralistic systems. But, I do think that there must be some controls. There must be some governing rules. Some standards. First for quality. Secondly for assurance that this quality is going to be provided to everybody, not on a basis of whether they can pay for it or not, because then you break down the whole premise. Thirdly, I believe that there is a need for establishing some regionalization. You know, some centers where you

DR. DeBAKEY: can't afford to dup.. That you can't afford to just duplicate in many places. In other words, the system as it now.. The system now permits, for example, poor quality care at high price. And that shouldn't be. That's not equal care any more. And it uneconomical. And we're paying a much higher price for it as a society. You see, whether you pay it or I pay it, the fact remains that somebody pays for it. There is no need, for example, in every hospital to have a pump team that does one or two or three pumps a week. That is not only uneconomical, that's poor quality work. Yet, there's no way to prevent that now. And it's being done and I see the results of it. I see the patients. I've got a patient I operated on Monday. I operated on two patients this week that were treated that way. Badly treated.

SCHANKE: Isn't that usually fatal?

DR. DeBAKEY: Not always. Yes, it usually is. But some unfortunately survive. Well, I did an operation today on a man for an aneurysm of the abdominal aorta. He was

DR. DeBAKEY: operated on about six weeks ago. And because he had an aneurysm of the abdominal aorta they thought it was too much for them. They shouldn't operate on a patient if they think it's too much for them. Why did they make an incision in the first place? You see? I've literally operated on dozens of patients like that. It's what we call a Blue Cross-Blue Shield operation. You see? They get a fee for it, even though they didn't do anything. They made the incision. Well,...

SCHANKE: The regional centers plan would..

DR. DeBAKEY: Would eliminate that. Sure. But you've got to have some teeth in the regional centers. You know. You've got to have some teeth in it. And the teeth would be the money. You would deny money to places that didn't..that would try to do this.

SCHANKE: I was upstairs one day when they brought in a man who had been operated on the day before in some not too far away Texas hospital. And he simply had to

SCHANCHE: be snipped open where you could get him..

It could have been one of those cases.

DR. DeBAKEY: Yeah, there are.. A high percentage of my work, I would say 20 percent of my work, are patients that I have to correct. Things that have been done incorrectly.

SCHANCHE: And you call these Blue Shield cases?

DR. DeBAKEY: Uh-huh.

SCHANCHE: A previous surgeon got it.

DR. DeBAKEY: Yeah. Got a Blue Shield fee for it. Well..

SCHANCHE: Blue Shield should try to do something to help.

DR. DeBAKEY: Well, they are, you know.

SCHANCHE: Oh, yes.

DR. DeBAKEY: They've already started in New York. They've already started.

SCHANCHE: What are they doing?

DR. DeBAKEY: What they're doing is saying to some of the hospitals we won't pay your hospitalization fee and we won't pay your surgeon's fee if you do this kind of work in that hospital. It's inadequate. They've already

DR. DeBAKEY: started. There's been a hue and cry about it. As a matter of fact they're talking about testing it by law. I hope they do. I think it's high time.

SCHANKE: I've missed that. I saw a thing on early admissions in hospitals which is a common practice up there. Have a patient on Friday when they don't need the patient until the following Tuesday, just to hold the bed over the week-end, which Blue Cross complained about it and was cracking down on it.

DR. DeBAKEY: Oh, yeah. I tell you the amount of money that's wasted is just terrible. Just terrible. That's why you've got to have some kind of a control. The medical profession can't control it. And somebody's got to control it. And, of course, they all howl as soon as you talk about controls, but it's got to be done. Society has got to ultimately control it. There are just too many abuses. And where there is money to made out of it, abuses will occur. There is no way to stop it. No way to stop it. That's one reason that I come closer in my thinking of how to provide

DR. DeBAKEY:       this care to the national health insurance program. And I'm sure that it can be set up. See, they'll be arguing with it about how to pay for it. Well, I mean, you can argue until you're blue in the face about the concept of whether everybody should get it-- whether or not they can afford. Well, what difference does that make. Everybody is getting it and that's the important thing. If you can afford to pay for it, then..you know and you get it, the person.. For example, the rich person should have equal access to care--the same kind of care, even though he can afford to pay for it. That's my point. I.. In other words, I've started off with a different basis--a different concept of health. I don't regard it as a commodity anymore. And as long as you do, then you see we're on a different plane of argument.

SCHANKE:            You regard it as a social guarantee.

DR. DeBAKEY:        Yes. I think it's a fundamental right. By God, if you're born, you ought to be healthy. That's the point I'm making. And if you're not, then you should



DR. DeBAKEY:

be provided with it. Or every effort made to make you healthy. So, that's the premise I started with. And that immediately, you see, reduces the absurdity of the arguments of whether or not you can afford to pay for it. Society's going to pay for it. A rich man says sure he can afford it, but let him pay what he..what everybody else pays. He's going to pay more taxation in some other area. You know, to support society. Now, the setting up of it so that there are guarantees of quality and guarantees of controls and so on then becomes a matter for experts to agree upon. And as far as I'm concerned, there are some very simple rules in that regard. Then the dispensation of it can be left to the private physician, private hospital. You use the same resources you have. There will be some doctors who won't make as much money, but they'll all make enough. There won't be any doctors in the poor house. They'll be making enough money to live on and live well.

SCHANCHE: You also feel that you should double the number of students.

DR. DeBAKEY: Well, I feel very strongly we should increase the number of doctors and also to.. I feel strongly that we should have.. The students should.. In other words, I feel quite strongly about this and have for a long time. That any member of our society who's capable of getting into medical school should be able to get in without any concern of the economics, you see. In other words, I think that here is an area in which we want the best minds we can get, wherever they come from. Therefore, there should be no economic screen to getting into the health profession. That's the point I'm making. And I testified before Congress about it.

SCHANCHE: There is a formidable economic screening, isn't there?

DR. DeBAKEY: Oh, yes. Oh, yes. I agree. Absolutely. Yeah. I testified before the Congressional committee on this fifteen years ago.

SCHANCHE: The solution here has to be federal scholarship programs.

DR. DeBAKEY: Yes, certainly.

SCHANCHE: And a large increase in the number of medical schools.

DR. DeBAKEY: Well, I'm not sure that there's a need for a large increase. I think that if you increase the capacity of those that are in operation today by giving them enough money, you can do the same job. You might have to increase, maybe another fifteen or twenty percent more medical schools. But if you took the medical schools that are in operation today and increased their capacity. Take Vanderbilt for example. They are still graduating about 75 or 80 students. They could graduate 150. You know, if they had the money.

SCHANCHE: Are there enough potential faculty available?

DR. DeBAKEY: No there isn't. No. You've got to increase that too. Sure. But you can't increase that unless you put money into it. You see. What I'm saying is you've got to put more money into this whole area.

SCHANCHE: It's not a question of lack of talent, it's a question of attractive positions.

DR. DeBAKEY: Exactly. Exactly. Sure. You know when the

DR. DeBAKEY: space program, for example, was cut down drastically, we had Ph. D's applying all over the place for jobs. Extremely capable people.

SCHANKE: All wanting to become medical.....

DR. DeBAKEY: Yeah, sure. Looking for jobs. Absolutely.

SCHANKE: The other night you mentioned to me that the intern program was going out and I wasn't aware of that. It's not dead yet, is it?

DR. DeBAKEY: Virtually. Yeah.

SCHANKE: You have no more interns here?

DR. DeBAKEY: We won't next year. We won't have any surgical interns. They'll all be residents. Right out of senior medical school into the residency program next year.

SCHANKE: And that does take a year off?

DR. DeBAKEY: Yeah.

SCHANKE: And that was the point behind your..

DR. DeBAKEY: But, you see, I.. There again. That's ten years has elapsed--more than ten years since I spoke against this. You know. It shows you the long delay.

DR. DeBAKEY: Mary Lasker and I were talking about that today--about the long delay.

SCHANKE: Is this.. This is true throughout the profession.

DR. DeBAKEY: Yes.

SCHANKE: What is this doing to the small hospitals which can't sustain residency programs?

DR. DeBAKEY: They'll have to stop. They get foreign people. That's what they're doing. They take foreigners.

SCHANKE: Pakistanies and ..

DR. DeBAKEY: Yeah, that's right. Cheap help. That's what they look for. And it is cheap. Both in quality as well.

SCHANKE: Yeah, well, I guess it always has been in that kind of hospital.

DR. DeBAKEY: Yeah, sure. That's right. Exactly.

SCHANKE: Was there a great deal of resistance to this?

DR. DeBAKEY: Well, sure. Sure.

SCHANKE: The practitioners?

DR. DeBAKEY: That's right.

SCHANKE: One of the things that makes for town-gown hospitals.

DR. DeBAKEY: That's right. Oh, yes. Well, you see, the main thing that creates the town-gown hospitals really is the money. Prestige and money. And most of the time they equate prestige with money.

SCHANKE: That's the American way, Mike.

DR. DeBAKEY: It's the American way. Absolutely. At one of the medical meetings in..at the AMA one year about seven, eight, nine years ago, something like that, they had a symposium. And they asked a number of doctors to try and discuss this town-gown thing. What could be done about it? And one of the doctors who went over there was from New Orleans walked up.. He was a participant. When he got up to speak, he said I'm going to make my statement very brief. He said I just want.. I'm going to show you one..the one thing that creates the town-gown controversy. And he pulled out a dollar bill and showed it. He said, "I've just reduced it to very simple terms. Here it is. That's the cause of it." (Laugh.)

SCHANKE: That's an eloquent resume.

DR. DeBAKEY: Yes. Yes. Sure. Yeah. Well, you know, some years ago, we had a.. The dean, Olson, set up a liason committee. with the Harris County Medical Society. And one of the..at the only meeting they had--they only had one meeting. He wanted me to be on it. And I said, "No, it would be best for me not to be on it." Well, he said, "You've got to be on it." I said, "Well, I'll come to the meeting if you want, but don't put me on the committee." So at this meeting, a couple of these doctors representing the Harris County Medical Society started talking about the private practice of medicine by the doctors in the medical school. They said they're full time, they shouldn't be doing private practice. And shouldn't be allowed to do private practice. They said they're doing teaching. So after he got through talking, I said, "Now look, you have a license to practice medicine." "Yes." "I have the same license

DR. DeBAKEY:

you have. I have the same justification for practicing medicine as you have, so far as a legal license is concerned." Now I said, "As far as qualifications certainly, as far as I'm concerned, my qualifications are just as good as yours." I said, "I believe they're better, but," I said, "let's just say they're as good, because I know you can't argue with that." I said, "What right have you got to say that because I am in the medical school and devoting a part of my time to teaching and research, that I shouldn't be practicing medicine." I said, "You have no right to make that judgement. None at all. Now what's your basis for doing it?" Well, he was absolutely stunned. And he couldn't say anything. He couldn't say anything. I put him on the spot in terms of his making a judgement that I shouldn't be practicing medicine. Now there was a stunned silence there for a while. And I said, "It's obvious you can't answer that question, but I'm going to give you an additional justification as far as I'm concerned."



DR. DeBAKEY:

I said, "The public has the right to seek medical attention wherever it finds it possible to do so. Secondly I have the right to practice medicine within my area of endeavor, because within that practice of medicine, I become a better teacher. Because of that I become a better teacher and a better researcher." So I said, "That is the additional justification. Aside from the fact that you have no right to make a judgment." Now I said, "As far as I'm concerned, that ends that part of the discussion. And I see no reason to discuss it any more."

SCHANKE:

Was that the end of the liason committee? (Laugh)

DR. DeBAKEY:

That was the end of the liason committee. (Laugh)  
There was never another meeting. So I told the dean--I told Olson after that, "You know, I don't see any purpose." I said, "I told you not to put me on the committee. I came with you because you insisted. There's no purpose in having this liason committee. There is no way you are going to resolve that kind

DR. DeBAKEY: of thinking. The whole basis for it is money. They don't want us to compete with them. That's all. It's just that simple. They can't compete with us and they don't want that kind of competition."

SCHANKE: Well, have you said enough?

DR. DeBAKEY: Well. (Laugh) No, I haven't said enough. There's a lot more I want to say.

SCHANKE: In drawing all this together, going back to that first outline that I wrote...

END SIDE A.

SIDE B (Unused.)